

NY STATE CLIENT SEMI-ANNUAL REPORT

Marking Instructions: Please type or use blue or black ink pen.
 Completely fill in one circle.
 Print legible numbers and block letters, no script.

COMPLETE ALL SECTIONS
 before submitting or form will be returned.

I Reporting Information

Year: **2013**
 Fill in circle if amendment ☒
 Report Period: ☒ January/June ☐ July/December
 Type of Lobbying: ☒ Nonprocurement ☐ Procurement ☐ Both
 Client Filing Fee Check Number: **#2055**

FOR OFFICE USE ONLY

Cym Amended to include Soft **Amendment**
132186
HAND DELIVERED
 Cit Name: Coal of NYS Pub Health Plans
RECEIVED JUL 15 2013
CHK# 2055 50

II Client Information

Name: **Coalition of Public Health Service Plans (NYS)**
 Permanent Business Address: **7 Times Square, 23rd Floor**
 City: **New York** State: **NY** ZIP code: **10036**
 Business Phone: **(212) 830-7237** Fax Number:
 Third Party Beneficiary (see instructions):

III Lobbyist(s) Information & Compensation (Current Period Only)

Any individual or organization that has lobbied on behalf of the client must be reported below, regardless of whether the threshold was exceeded by that individual or organization.

A Type of Lobbyist: ☒ Retained ☐ Employed ☐ Designated
 Level of Gov't: ☒ State Lobbying ☐ Local Lobbying ☐ Both
 Name: **Maratt Phelps + Phillips** Phone Number: **(518) 431-6700**
 Address: **7 Times Square, 23rd Floor**
 City: **New York** State: **NY** ZIP code: **10036**
 Compensation for current period: \$ **120,000.00**

B Type of Lobbyist: ☐ Retained ☐ Employed ☐ Designated
 Level of Gov't: ☐ State Lobbying ☐ Local Lobbying ☐ Both
 Name:
 Address:
 City:
 State:
 ZIP code:
 Compensation for current period: \$ **.00**

C Type of Lobbyist: ☐ Retained ☐ Employed ☐ Designated
 Level of Gov't: ☐ State Lobbying ☐ Local Lobbying ☐ Both
 Name:
 Address:
 City:
 State:
 ZIP code:
 Compensation for current period: \$ **.00**

☐ Continued on attached pages

D TOTAL COMPENSATION of ALL lobbyists for current period.....(A+B+C+addendum sheets): \$ **120,000.00**

IV Other Expenses (Current Semi-Annual Period Only)

A Report in the aggregate all expenses less than or equal to \$75: \$ 100 .00

B Report in the aggregate all expenses for salaries of non-lobbying employees: \$ 0 .00

C Itemize each expense exceeding \$75:

PAID TO: Maratt Phelps Phillips DATE: 2/28/2013 ☐ Ad ☐ Social Event

PURPOSE: lobby day dinner AMOUNT: \$ 445.00 ☐ *Addendum attached

☐ PROCUREMENT ☒ NONPROCUREMENT

PAID TO: DATE: / / ☐ Ad ☐ Social Event

PURPOSE: AMOUNT: \$.00 ☐ *Addendum attached

☐ PROCUREMENT ☐ NONPROCUREMENT

☐ Continued on attached pages

* If any expense listed above exceeds \$75 for an individual, you must attach the addendum page listing the expense, dollar amount attributable to the individual and the name, title and employer of the individual.

D Total expenses for current period: \$ 545.00 (if applicable, include all expenses from attached pages in total)

V Source of Funding Disclosure

Instructions: In the event only one person or entity is listed as the Single Source for a Contribution(s), use Section A. In the event multiple persons or entities have been aggregated as a Single Source for a Contribution(s), use Section B.

A Below, list all Contributions received from the Single Source. Include the date and the amount of the Contribution received. If more than five Contributions from the Single Source have been received, use section V(C) of the Addendum for the additional Contributions.

Contribution(s) from Single Source #1

Single Source Entity's Name: Affinity Health Plan

or
Single Source Person's Last Name First Name:

Address: 2500 141st St.

City: Bronx State: NY ZIP code: 10461

Phone: (718) 794-7691

Date Contribution Received: <u>2/1/2013</u>	Amount of Contribution: \$ <u>17,655</u> .00
Date Contribution Received: / /	Amount of Contribution: \$.00
Date Contribution Received: / /	Amount of Contribution: \$.00
Date Contribution Received: / /	Amount of Contribution: \$.00
Date Contribution Received: / /	Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

Contribution(s) Single Source #2

Single Source Entity's Name: Amica care

or
Single Source Person's Last Name First Name:

Address: 248 West 35th St, 7th Floor

City: New York State: NY ZIP code: 10001

Phone: (646) 786-1804

Date Contribution Received: <u>2/1/2013</u>	Amount of Contribution: \$ <u>11,413</u> .00
Date Contribution Received: / /	Amount of Contribution: \$.00
Date Contribution Received: / /	Amount of Contribution: \$.00
Date Contribution Received: / /	Amount of Contribution: \$.00
Date Contribution Received: / /	Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

Check here if there are Contribution(s) from Single Source(s) other than those listed above. Use Section V(A) of the Addendum to list all such Contributions: ☐

Designated Addendum sheet for section V(A)

Please use the following addendum pages as continuation for the specified sections. If additional space is needed, please make a copy of this sheet.

V Source of Funding Disclosure

A Below, list all Contributions received from the Single Source. Include the date and the amount of the Contribution received.

Contributions from Single Source #3

Single Source Entity's Name: *Fidelis Care New York*
 or
 Single Source Person's Last Name: First Name:
 Address: *95-25 Queens Blvd. 8th Floor*
 City: *Rego Park* State: *ny* ZIP code: *11374*
 Phone: *(718) 393-6101*
 Date Contribution Received: *2/1/2013* Amount of Contribution: \$ *31,807* .00
 Date Contribution Received: */ /* Amount of Contribution: \$.00
 Date Contribution Received: */ /* Amount of Contribution: \$.00
 Date Contribution Received: */ /* Amount of Contribution: \$.00
 Date Contribution Received: */ /* Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

Contributions from Single Source #

Single Source Entity's Name: *Healthfirst PHSP*
 or
 Single Source Person's Last Name: First Name:
 Address: *100 Church St.*
 City: *New York* State: *ny* ZIP code: *10007*
 Phone: *(212) 801-1500*
 Date Contribution Received: *2/1/2013* Amount of Contribution: \$ *30,124* .00
 Date Contribution Received: */ /* Amount of Contribution: \$.00
 Date Contribution Received: */ /* Amount of Contribution: \$.00
 Date Contribution Received: */ /* Amount of Contribution: \$.00
 Date Contribution Received: */ /* Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

Contributions from Single Source #

Single Source Entity's Name: *Hudson Health Plan*
 or
 Single Source Person's Last Name: First Name:
 Address: *303 South Broadway, Suite 321*
 City: *Tarrytown* State: *ny* ZIP code: *10591*
 Phone: *(914) 631-1611*
 Date Contribution Received: *2/1/2013* Amount of Contribution: \$ *14,174* .00
 Date Contribution Received: */ /* Amount of Contribution: \$.00
 Date Contribution Received: */ /* Amount of Contribution: \$.00
 Date Contribution Received: */ /* Amount of Contribution: \$.00
 Date Contribution Received: */ /* Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

Designated Addendum sheet for section V(A)

Please use the following addendum pages as continuation for the specified sections. If additional space is needed, please make a copy of this sheet.

V Source of Funding Disclosure

A Below, list all Contributions received from the Single Source. Include the date and the amount of the Contribution received.

Contributions from Single Source #3

Single Source Entity's Name:

Metro PLUS

or

Single Source Person's Last Name:

First Name:

Address:

160 Water St. 3rd FL

City:

New York

State:

NY

ZIP code: 10038

Phone:

Date Contribution Received:

2/1/2013

Amount of Contribution: \$

21,550.00

Date Contribution Received:

/ /

Amount of Contribution: \$

.00

Date Contribution Received:

/ /

Amount of Contribution: \$

.00

Date Contribution Received:

/ /

Amount of Contribution: \$

.00

Date Contribution Received:

/ /

Amount of Contribution: \$

.00

Check here if using section V(C) of the Addendum for additional Contributions:

☐**Contributions from Single Source # _____**

Single Source Entity's Name:

Monroe Plan for Medical Care

or

Single Source Person's Last Name:

First Name:

Address:

1120 Pittsford-Victor Rd.

City:

Pittsford

State: NY

ZIP code: 14534

Phone:

(585) 256-8404

Date Contribution Received:

2/1/2013

Amount of Contribution: \$

16,516.00

Date Contribution Received:

/ /

Amount of Contribution: \$

.00

Date Contribution Received:

/ /

Amount of Contribution: \$

.00

Date Contribution Received:

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Amount of Contribution: \$

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Date Contribution Received:

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Amount of Contribution: \$

.00

Check here if using section V(C) of the Addendum for additional Contributions:

☐**Contributions from Single Source # _____**

Single Source Entity's Name:

or

Single Source Person's Last Name:

First Name:

Address:

City:

State:

ZIP code:

Phone:

Date Contribution Received:

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Amount of Contribution: \$

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Date Contribution Received:

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Check here if using section V(C) of the Addendum for additional Contributions:

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Designated Addendum sheet for section V(A)

Please use the following addendum pages as continuation for the specified sections. If additional space is needed, please make a copy of this sheet.

V Source of Funding Disclosure

A Below, list all Contributions received from the Single Source. Include the date and the amount of the Contribution received.

Contributions from Single Source #3*Total care*

Single Source Entity's Name:

or

Single Source Person's Last Name:

First Name:

Address: *Syracuse Comm. Health Ctr, 819 S. Salina St.*City: *Syracuse* State: *NY*ZIP code: *13202*Phone: *(315) 476-7921 ext 2425*Date Contribution Received: *2/1/2013* Amount of Contribution: \$ *12,140* .00Date Contribution Received: */ /* Amount of Contribution: \$.00Date Contribution Received: */ /* Amount of Contribution: \$.00Date Contribution Received: */ /* Amount of Contribution: \$.00Date Contribution Received: */ /* Amount of Contribution: \$.00Check here if using section V(C) of the Addendum for additional Contributions: ☐**Contributions from Single Source #** _____

Single Source Entity's Name:

or

Single Source Person's Last Name:

First Name:

Address: *1250 Broadway 11th Floor*City: *New York* State: *NY*ZIP code: *10001*Phone: *(212) 609-5631*Date Contribution Received: *2/1/2013* Amount of Contribution: \$ *11,419* .00Date Contribution Received: */ /* Amount of Contribution: \$.00Date Contribution Received: */ /* Amount of Contribution: \$.00Date Contribution Received: */ /* Amount of Contribution: \$.00Date Contribution Received: */ /* Amount of Contribution: \$.00Check here if using section V(C) of the Addendum for additional Contributions: ☐**Contributions from Single Source #** _____

Single Source Entity's Name:

or

Single Source Person's Last Name:

First Name:

Address:

City: State:

ZIP code:

Phone:

Date Contribution Received: */ /* Amount of Contribution: \$.00Date Contribution Received: */ /* Amount of Contribution: \$.00Date Contribution Received: */ /* Amount of Contribution: \$.00Date Contribution Received: */ /* Amount of Contribution: \$.00Date Contribution Received: */ /* Amount of Contribution: \$.00Check here if using section V(C) of the Addendum for additional Contributions: ☐

VI Subjects lobbied:

Issues affecting the operations and finances of prepaid health service plans, including Medicaid Managed care, child Health Plus and family Health Plus

☐ Continued on attached pages

VII Person, State Agency, Municipality or Legislative Body lobbied:

NYS Assembly, NYS Senate, Governor's office and relevant state agencies

☐ Continued on attached pages

VII Bill, Rule, Regulation, Rate Number or brief description relative to the introduction or intended introduction of legislation or a resolution on which you lobbied:

S2600B, A3000B, S3601, A3001, S2602, S3002, S2603B, A3003B, S2604B, A3004B, S2609B, A3008B, S2608B, A3007B, S2606B, A3005B, S3605B,

☐ Continued on attached pages

VIII Title and Identifying Numbers of procurement contracts/documents lobbied:

n/a

☐ Continued on attached pages

IX Number or Subject Matter of Executive Order of Governor/Municipality lobbied:

n/a

☐ Continued on attached pages

X Subject Matter of and Tribes involved in tribal-state compacts, etc lobbied:

n/a

☐ Continued on attached pages

XI Declaration

This Declaration must be signed by the Chief Administrative Officer. (If the Chief Administrative Officer, for any reason, does not sign, he/she must duly designate another person to sign this Declaration.) (See instructions.)

I declare under penalty of perjury that the information contained in this report is true, correct, and complete to the best of my knowledge and belief.

X SIGNATURE:

DATE: July 15, 2013

PRINT NAME: LAST

FIRST

TITLE:

Mark One: ☐ Chief Administrative Officer ☐ Designee (Attach Letter)

The following MUST be attached to this report at the time of submission:

--You must attach a **\$50 dollar filing fee** to each semi-annual report. (No fee is required for amendments to the original)

--If applicable, a designation letter if you have marked designee in section XI.

--If applicable, continuation sheets for sections III, IV, V, VI, VII, VIII, IX and X.

PLEASE NOTE You may be assessed up to \$25 for each day this report is late.